145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Remicade®(Infliximab), Enbrel® (Etanercept), Kineret® (Anikinra), Humira® (Adalimumab) Orencia® (Abatacept) Stelara®(Ustekinumab)

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.
4. **Please fax completed form to NexgenRx Formulary Management at 647-722-3054 (Toronto Area) / (Toll Free Fax) 1-866-262-0007 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z 5M4**

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:																				
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE		
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Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy):_____

Section 2: To be completed by Physician/ Pharmacist

Drug Name:	Drug Strength:	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ❑ To reduce the signs of moderate to severe active rheumatoid arthritis in adult patients
- ❑ To reduce the signs and symptoms of moderate to severe active rheumatoid arthritis, in combination with methotrexate, in adults
- ❑ To reduce the signs and symptoms of moderate to severe active Crohn's disease in patients who have an inadequate response to standard therapy
- ❑ To treat fistulising Crohn's disease in adults who have failed to respond to standard therapy
- ❑ To treat moderate to severe active polyarticular-course juvenile rheumatoid arthritis in patients aged 4-17 who have failed to have an adequate response to standard DMARDS
- ❑ To reduce the progression of structural damage of active arthritic disease in adult patients with psoriatic arthritis
- ❑ To treat chronic moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy
- ❑ To treat ankylosing spondylitis

Physician / Pharmacist Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician / Pharmacist: _____	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: _____ Pharmacist's Name: (Print Last, First) _____	E-mail:

Internal Office Use Only:

Date Received:	DIN Number:	HICL:	Date Approved:
Effective Date:	Termination Date:	Approved: YES or NO	Approved by:
Notified: Pharmacist's Name	Notification Date		